FRONTIER BEHAVIORAL HEALTH
509.838.4651 107 S Division, Spokane WA 99202 www.fbhwa.org

Revocation of ROI

FRONTIER BEHAVIORAL HEALTH

Name:_____ Request Date:_____

Phone:_____ FBH ID#:_____

Social Security Number:_____ Date of Birth: _____

I, _____, hereby revoke the release of information authorization dated: _____, to which I authorized the disclosure of my health information shared between Frontier Behavioral Health and:

(Name of Recipient) _____

This revocation is effective this date: _____.

Note: *One revocation form per each signed authorization must be completed.*

SIGNATURE: _____ **DATE**: _____

If the individual is 12 years of age or younger, or is a dependent adult, a Parent or the Legal Guardian must sign:

SIGNATURE: _____ DATE: _____

Parent/Legal Guardian/Representative

PRINTED NAME: _____ RELATIONSHIP: _____

WITNESS SIGNATURE: _____ DATE: _____